

Case Number:	CM15-0160596		
Date Assigned:	08/27/2015	Date of Injury:	01/06/2003
Decision Date:	10/06/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/17/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania, Ohio, California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 64-year-old male who sustained an industrial injury on 1-6-03 from a motor vehicle accident injuring her back, buttocks, left leg, bilateral knees, neck, shoulders and arms. She currently (7-13-15) complains of constant back and leg pain with a pain level of 8-9 out of 10. On physical exam, there was tenderness and spasm of the cervical spine with decreased range of motion, positive bilateral straight leg raise. In the 5-12-15 note, the injured worker admits that her medications are not helping with her pain but she is taking them. Diagnoses include cervical spine myofascitis with radiculitis; lumbar spine myofascitis with radiculitis, status post-surgery; rule out cervical disc injury. Drug testing was done 6-8-15 and was consistent with prescribed medications. Treatments to date include transforaminal epidural steroid injection left L4-5 and L5-S1 with 100% relief for 3 months (10-2014). Diagnostics include electromyography, nerve conduction study (6-1-15) of bilateral lower extremities showing normal results. In the progress note dated 7-13-15 the treating provider's plan of care included requests for Oxycontin 30 mg #60; Percocet 10-325mg #60; Cyclobenzaprine 7.5mg #60 (per RFA 7-13-15).

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Cyclobenzaprine 7.5 mg Qty 60 (retrospective dispensed 7/13/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: MTUS recommends the use of non-sedating muscle relaxants for short-term use only. This guideline recommends Cyclobenzaprine/Flexeril only for a short course of therapy. The records in this case do not provide an alternate rationale to support longer or ongoing use. This request is not medically necessary.

Oxycontin 30 mg Qty 60, 1 tab by mouth 2 times daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, criteria for use.

Decision rationale: MTUS discusses in detail the 4 As of opioid management, emphasizing the importance of dose titration vs. functional improvement and documentation of objective, verifiable functional benefit to support an indication for ongoing opioid use. MTUS also discourages the use of chronic opioids for back pain due to probable lack of efficacy. The records in this case do not meet these 4As of opioid management and do not provide a rationale or diagnosis overall, for which ongoing opioid use is supported. Therefore, this request is not medically necessary.

Percocet 10/325 mg Qty 60, 1 tab by mouth 2 times daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: MTUS discusses in detail the 4 As of opioid management, emphasizing the importance of dose titration vs. functional improvement and documentation of objective, verifiable functional benefit to support an indication for ongoing opioid use. MTUS also discourages the use of chronic opioids for back pain due to probable lack of efficacy. The records in this case do not meet these 4As of opioid management and do not provide a rationale or diagnosis overall, for which ongoing opioid use is supported. Therefore, this request is not medically necessary.